(b) whether during a review meeting with senior officials of the various Ministries it was suggested to restructure the Integrated Disease Surveillance Programme and transform it into and early warning system;

(c) if so, what are the other suggestions made by the PM;

(d) to what extent his Ministry has considered them; and

(e) by when they are likely to be revamped?

THE MINISTER OF STATE IN THE MINISTRY OF HEALTH AND FAMILY WELFARE (SHRIMATI PANABAKA LAKSHMI): (a) to (c) Yes, Sir. Prime Minister reviewed Dengue, Chickungunya and other vector-borne diseases on 02nd November 2006 and directed that the Integrated Disease Surveillance Project should incorporate early warning system as part of disease surveillance under National Vector Borne Disease Control Programme (NVBDCP) and National Rural Health Mission (NRHM). The Prime Minister also suggested that there should be close interaction between the Ministry of Health & Family Welfare and local bodies on sharing of information, health alerts, and orientation sessions for health professionals in order to prevent the epidemic. Steps for improved sanitation and prevention of mosquitogenic were also suggested.

(d) and (e) Ministry has initiated the process to establish and manage Information Technology network connecting all States, District headquarters and Government Medical Colleges as well. National Informatics Centre has been asked to develop a centralised Call Centre to receive outbreak alerts. Baseline survey of laboratories in all districts covered under Phase-I and II of the programme has been carried out for their strengthening. Rapid Response Teams have also been identified & trained in these districts guidelines for action by villages and sanitation committees have been sent to States. These activities have been envisaged to help the State Governments to rapidly detect and respond to outbreak of epidemic prone diseases.

Increase in health care spending

497. SHRI JANARDHANA POOJARY: Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) whether cost of health care in the country is increasing consistently over the last few years;

(b) if so, the details thereof;

(c) whether medical tourism is one of the contributing factors;

(d) if so, the details thereof;

(e) whether WHO in its 'World Health Survey' has reported that in India over 16 per cent of the population were pushed below poverty line, 12 per cent had to sell their assets to meet health expenses and 43.3 per cent had to borrow from outside the family to cover health costs;

(f) if so, the details thereof and Government's reaction thereto; and

(g) the measures taken to make health care easily accessible and affordable to the poor?

THE MINISTER OF HEALTH AND FAMILY WELFARE (DR. ANBUMANI RAMDOSS): (a) and (b) yes, Sir. According to the report of the NSS 60th Round (January—June 2004)-Morbidity, Health Care and the Condition of the Aged, the average medical expenditure per hospitalization case, has increased from Rs. 2202 in 1996-97 to Rs. 5695 in 2004 in rural areas and from Rs. 3921 to Rs. 8851 in the urban areas.

(c) No, Sir.

(d) Does not arise.

(e) to (g) The World Health Survey-India, 2003 was conducted in six States *viz.* Assam, Karnataka, Maharashtra, Rajasthan, Uttar Pradesh and West Bengal. According to the findings of the survey, *inter alia*, 16% of the households reported that they paid their health care expenditure through borrowed sources, 9% through savings (bank account) and 11% of the households paid through income from outside the family. About seven per cent of the households financed their health spending by selling household assets as furniture, cattle, jewellery, etc. and less than one per cent of households relied on health insurance to meet their health payments.

The study also indicates that a non poor household is impoverished by health payment and is pushed in to poverty in the absence of insurance coverage and lack of protectional measures by other health reimbursement scheme.

In order to provide effective healthcare to the rural population throughout the country with special focus on18 States with poor health indicators and weak health infrastructure, the Government has launched the National Rural Health Mission in April, 2005. The Mission adopts a synergistic approach by relating health to determinants of good health and the main objective is to provide accessible, affordable, accountable and reliable health care especially to the poor and vulnerable sections of the population. Further, the gaps in the existing scenario of rural health care are being addressed through involvement of the community, the Panchayati Raj Institutions and other non-governmental organizations. An accredited social health activist will act as a link between the community and the healthcare system.

Clinical trial of drugs

498. SHRI JANARDHANA POOJARY: Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) whether it is proposed to set up a Central Drug Authority of India (CDAI) to equip the drug regulator with enough resources;

(b) if so, the details in this regard;

(c) whether it is a fact that a number of drugs without following the Good Manufacturing Practice, proper clinical trials and also spurious drugs are being sold in the market across the country involving even critical life saving drugs; and

(d) if so, the details with number of such cases detected and the action taken during the last three years?

THE MINISTER OF STATE IN THE MINISTRY OF HEALTH AND FAMILY WELFARE (SHRIMATI PANABAKA LAKSHMI): (a) Yes, Sir.

(b) The proposed Central Drug Authority of India (CDAI) will be an autonomous body under MOH&FW with ten divisions dealing with specific subjects.

(c) Drugs are being approved in the country, based on Safety, Efficacy and Quality Control data furnished by the applicant as per Drugs and Cosmetics Rules. The Drugs and Cosmetics rules are continuously